

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2014
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, COOKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies Based on observations, testing and document review, it was determined the facility had no life safety deficiencies.	N 002	Effective, February 13, 2014 a quality assurance program was implemented under the supervision of the plant operations director to monitor the usage of power-strips. The plant operations director or designated quality-assurance representative will perform the following systematic changes: a review of all patient rooms will be conducted. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. The Quality Assurance Committee consists of the Medical Director, Director of Nursing, Director of HIM, Director of Dietary and Administrator. (End Tag K147)	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jeremy Stoner, NHA - Administrator - 2/21/2014

STATE FORM

0090

S0XG21

If continuation sheet 1 of 1

Division of Health Care Facilities

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Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Administrator

2/14/2014

STATE FORM

5899

S0XG21

If continuation sheet 1 of 1